California Public Employees' Retirement System
P.O. Box 94229-2714
Sacramento, CA 94229-2714

CalPERS

SAMPLE
Changing Insurance Carrier

HEALTH BENEFIT PLAN ENROLLMENT FORM
PERS-HBD-12 (Rev.8/10)

DO NOT SEND MEDICAL CLAIMS TO THIS ADDRESS

CalPERS USE ONLY - DOCUMENT REFERENCE NUMBER

PLEASE TYPE

1. TYPE OF ACTION (Check One)
- ☐ a. NEW enrollment
- ☒ b. CHANGE of coverage
- ☐ c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER: 777 — 77 — 7777

3. SPOUSE/DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER: 222 — 22 — 2222

4A. Name: John M. Doe

Mailing Address: 1201 Anywhere Lane

City, State, ZIP: Torrance, CA 90503 | Daytime Phone: (310) 111-1111 | Evening Phone: (310) 222-2222

4B. RESIDENCE ZIP CODE (If different from 4A)

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

6. GENDER: ☒ Male ☐ Female

7. MARRIED: ☒ Yes ☐ No

8. PLAN CODE: 0623

9. NAME OF HEALTH PLAN: Blue Shield NetValue

10. GROSS PREMIUM: $ 1,111.71

11. PRIMARY CARE PHYSICIAN/MEDICAL GROUP: Dr.Lynn Coates/00A356170

12. PRIOR PLAN CODE: 3023

13. PRIOR HEALTH PLAN: Blue Shield Access +HMO

14. Reason Code: 400

15. Permitting Event Date: Mo. 09 | Day 13 | Yr. 2010

16. EFFECTIVE DATE: Mo. 01 | Day 01 | Yr. 2011

ACTION

LIST ALL PERSONS (including self) TO BE ENROLLED IN:

17. BASIC PLAN	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	GENDER M	F	CODE
(FIRST) (MI) (LAST) John M. Doe	02	05	50	SELF	☒	☐	
SSN 777-77-7777							
(FIRST) (MI) (LAST) Jane C. Doe	05	01	53	Wife	☐	☒	
SSN 222-22-2222							
(FIRST) (MI) (LAST) Joanne F. Doe	09	09	10	Dtr	☐	☒	
SSN 333-33-3333							
(FIRST) (MI) (LAST)					☐	☐	
SSN							

ACTION

18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Relationship	CODE

19. CHECK ONE
- ☐ I **DO NOT** elect to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☒ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy): John M. Doe

TELEPHONE NUMBER (310) 222-2222

21. DATE SIGNED: Mo. 09 | Day 15 | Year 2010

PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22-27

22. DEDUCTION PLAN CODE	23. Type of action (Check One)	24. PAY PERIOD Month	Year	25. PARTY CODE	26. EMPLOYEE DESIGNATION	27. BARGAINING UNIT
	1. ☐ New 2. ☐ Cancel 3. ☐ Change					

28. AGENCY NAME (or Retirement System)	29. PAYROLL OFFICE CODE	30. AGENCY CODE	31. UNIT CODE
City of Torrance	5	0158	

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825-22832 or the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

SIGNATURE OF HEALTH BENEFITS OFFICER

33. Date received in employing office: Mo. | Day | Year

34. PHONE NUMBER ( )

35. REMARKS

_____ of _____ Forms

WHITE - HB PINK - Agency BLUE - Employee